Pamoja Tuwalee

PAMOJA TUWALEE PROGRAM/FHI360 - COAST ZONE
Cooperative Agreement No. 621-A-00-10-00027-00
Quarterly Performance Narrative Report
October to December 2015

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Table of Contents

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CRP	Community Resource Person
CSO	Civil Society Organization
DCPT	District Child Protection Team
DED	District Executive Director
DIPG	District Implementing Partner Group
DSW	Department of Social Welfare
DSWO	District Social Welfare Officers
GBV	Gender Based Violence
FHI 360	Family Health International
HACOCA	Huruma AIDS Concern and Care
HIV	Human Immune deficiency Virus
IPG	Implementing Partners Group
LGA	Local Government Authority
MCDGC	Ministry of Community Development Gender and Children
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium-Term Expenditure Framework
MVC	Most Vulnerable Children
MVCC	Most Vulnerable Children Committee
NCPA II	National Coasted Plan of Action for Most Vulnerable Children
NGO	Non-Governmental Organization
OSC	One Stop Centre
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief

PSS	Psychosocial Support
SILC	Savings and Internal Lending Communities
TZS	Tanzanian Shillings
UNICEF	United Nations International Children's Emergency Fund
US $	United States of America Dollar
USAID	United States Agency for International Development
USG	United States Government
VAC	Violence Against Children
WAMATA	Walio Katika Mapambano ya Ukimwi Tanzania (Fight against HIV)
YAM	Youth Alive Movement
ZAMWASO	Zanzibar Muslim Women Association to Support Orphans
ZCPA	Zanzibar Costed Plan of Action

EXECUTIVE SUMMARY

Pamoja Tuwalee is a USAID funded program that is to operate from June 2010 to March 2016. The program covers five zones of Coast, Central, Lake, Northern and Southern and is implemented by four partners with FHI 360 covering the Coast Zone i.e. Dar es Salaam, Morogoro and Pwani regions in the mainland and Zanzibar. Currently, the program is implemented in partnership with seven local Civil Society Organizations (CSOs), and in collaboration with 25 Local Government Authorities (LGAs) and community members. The Program goal is to improve the quality of life and well-being of Most Vulnerable Children (MVC) and their households.

This report is for the first quarter of Fiscal Year (FY) 2016. It narrates the implementation of the planned activities, achievements, challenges encountered and planned activities for next quarter.

Based on the proposed eight month extension, the program main activities for this quarter were: increased HIV services to MVC and their caretakers; identification of MVC to increase target within scale up districts with a focus on HIV+ MVC and adolescents; and continued provision of services to MVC and their households within all the operational districts. These were implemented in collaboration with LGAs and facility based HIV partners. Efforts were made to identify and enrol new HIV+ MVC, adolescents and caretakers through referral provision for HTC services. As a result, a total of 3,217 HIV+MVC were assessed using MUAC tape, they were educated on hygiene, living positively with HIV, and counselled on nutrition issues. In addition, 3826 (1424 male and 2402 female) HIV+ MVC were reached with ART adherence and nutrition counselling and support through home visits by community volunteers. 1,184 MVC, adolescents and caretakers were referred to health facilities and other stakeholders for health and HIV related services including HTC. The increase is a result of the training of youth volunteers and other program initiatives. Moreover, 4305 MVC and caretakers were supported to access HIV related services at health facilities and other institutions. The services were treatment for opportunistic infection, hygiene education.

As part of scale up, MVC identification was conducted in 35 wards of Ilala, Kinondoni and Morogoro municipal councils. The exercise identified more than 80,000 MVC and their households, however conclusive number will be shared after processing of the collected data next quarter.

Efforts to mobilize resources for OVC support continued this reporting period whereby TZS 97,785,00O was collected from stakeholders in the public and private sectors. The same was used to support 7,073 (3,389 male and 3,684 female) MVC with their basic needs. Also, promotion of SILC initiative continued resulting into formation of 62 new groups Cumulative SILC group savings increased by 28% to TZS 2,449,953,751 (US$1,166,644) from TZS 1,921,247,721 reported last quarter. Also, cumulative OVC fund grew to TZS 161,209,360 (US$ 76,766) equivalent to 20% when compared to the last quarter amount of TZS 134,278,040.

Service provision to MVC, adolescents and caretakers continued during the reporting period. A total of 82,087 (38,908 male and 43,186 female) received at least one core service. This is 38% achievement of the annual target of 216,792 MVC. The number is expected to rise drastically upon enrolment of newly identified MVC next quarter.

PROGRAM IMPLIMENTATION

INTRODUCTION

Pamoja Tuwalee program is funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID). It covers the period of June 2010 to March 2016. The program is implemented by four partners in five zones namely: Coast, Central, Lake, Northern and Southern. FHI 360 covers the coast zone which includes Dar es Salaam, Morogoro and Pwani regions in the Mainland, Unguja and Pemba in Zanzibar. The goal of this program is to improve the quality of life and well-being of Most Vulnerable Children (MVC) and their households by empowering households and communities to provide comprehensive and sustainable care.

Coast zone is bordered by Indian Ocean on the East Coast and regions of Iringa, Dodoma, Tanga and Lindi on the other sides in mainland Tanzania. Unguja and Pemba are islands, surrounded by the Indian Ocean. The program target was to cover all 26 districts in the zone. However, it was noted that PASADA who is a major partner also receives funds from USAID and operates in Temeke district in Dar es Salaam region, thus, it was decided to leave Temeke to PASADA and Pamoja Tuwalee/FHI360 to cover Ilala and Kinondoni districts in order to avoid overlapping and double counting of results. Hence, the program covers a total of 25 districts: 2 in Dar es Salaam, 6 in Morogoro, 7 in Pwani and 10 in Zanzibar. However, next quarter i.e. quarter two of FY 2016, the program plans to scale up to Temeke. It will officially takeover OVC currently under PASADA where the latter will concentrate on facility based HIV services.

The current population[1] in Coast zone is estimated at 8, 985,270. Dar es Salaam has the highest number of people (4,364,541) followed by Morogoro (2,218,492), Zanzibar islands (1,303,569) and Pwani region (1,098,668). Based on the estimated proportion of 51% children in the general population, the estimate of children in Coast zone is 4,582,488.

HIV prevalence is highest in Dar es Salaam recorded at 6.9% which is above the National prevalence rate of 5.1%[2]. Next is Pwani region with a prevalence rate of 5.9%, followed by Morogoro at 3.8% and Zanzibar with 1%. HIV/AIDS has adverse multiplier effects to the Tanzanian society in all socio-economic arenas leading to economic instability and leaving many children as orphans.

During this reporting period, a total of 82,087(38,908 male and 43,186 female) MVC and their caretakers were reached with one core service. This is equivalent to 38% of the annual target of 216,792 and it makes the cumulative number of MVC served 143,724. The MVC were reached with direct support, referrals and linkages while caretakers received different training and support including HIV and AIDS education, economic strengthening, nutritional counselling and MVC caretaking skills.

[1] National census 2012

[2] TACAIDS

Table 1: Program Geographical Coverage and MVC Reach

Region	Dar es Salaam	Pwani	Morogoro	Zanzibar	Total
Total # of Sub grantee per region	1	2	3	2	8
Total # of districts	3	7	6	10	26
Total # of districts reached	2	6	6	10	24
Total # of wards in the covered region	60	97	170	321	648
# (%) of wards covered by the program	20 (33%)	97 (100 %)	108 (64%)	74 (23%)	299 (46%)
Total # of villages in the region	273	621	916	NA	1810
# (%) villages covered by the program	92 (34%)	432 (70%)	587 (65%)	NA	1111 (61%)
5 years targeted # of Households	2,500	7,101	1,568	901	12,070
Initial LOP targeted # of MVC	5,001	28,405	6,272	3,605	43.283
Revised LOP targeted # of MVC	12,738	29,817	14,974	8,253	65,782
New targeted # of MVC - FY 2016	166,832	19,396	24,462	6,102	216,792
# of MVC and Caregivers ever enrolled	23,392	69,885	34,461	15,986	143,724
# of MVC and Caregivers current in the program	18085	49618	22,323	5035	95,061
# of MVC and caregivers served: Oct to Sept 2015	16,408	45,238	17,388	3,053	82,087
MVC and caregivers Served: sex disaggregation: October -December 2015					
Male	7,051	22,194	8,182	1,474	38,901
Female	9,357	23,044	9,206	1,579	43,186
MVC and caregivers Served: Age disaggregation: October -December 2015					
<1 Years	25	522	28	9	584
1-4 Years	935	3,664	1039	280	5,918
5-9 Years	2,620	8,638	3,437	677	15,372
10-14 Years	4,516	11,613	4,526	859	21,514
15-17 Years	2,381	5,788	1,965	392	10,526
18-24 Years	539	1057	249	77	1,922
25+ Years	5,392	13,956	6,144	759	26,251
Total	**16,408**	**45,238**	**17,388**	**3,053**	**82,087**

PROGRAM ADMINISTRATION AND MANAGEMENT

Life of Project Funding and Duration

Although the program is currently planned to end in March 2016, during the quarter we were notified by the donor about a proposed eight month extension from April to November 2016. The extension will entail: scale up to a new District of Temeke and into new wards within the current scale up districts of Ilala, Kinondoni and Morogoro municipal councils with a focus on HIV+ children and those at high risk of HIV infection; transitioning of all MVC and their households within the existing 21sustained districts; initiation of DREAMS intervention in Temeke district targeting 1191 girls of ages 10-14 years; improving record keeping and documentation of applied successful approaches that ensure the continuum of care for HIV infected and affected OVC and their families; and updating of PMP to include PEPFAR required indicators and SIMS. It also entail increase in the estimated award amount.

The program key documents were revised accordingly to reflect the above. These include program description, budget, work plan for FY 2016 and PMP. The same were submitted to the donor for review and approval. Although Modification on the same is expected in the second quarter, some preparatory / preliminary activities for scale up continued this quarter, including identification of new MVC per the national guidelines ready for enrolment into the program next quarter.

Staffing

The program staffing level remained the same as that of last quarter as no new members were recruited and luckily there were no departures. In the next quarter, it is planned to recruit two additional staff in the positions of Technical Officer who will join Dar es Salaam regional team due to the expected scale up to Temeke district; and Monitoring and Evaluation Officer who will be at the program headquarter with the other two M&E staff to handle the increased M&E workload resulting from increased targets and expanded geographical coverage.

Sub grantee Planning Meeting for FY 2016

Following the proposed extension reported above, during this quarter the program facilitated all seven sub grantees to develop their plans and the pertaining budgets for FY 2016. The planning meeting was preceded by reflection on FY 2015 performance; experience sharing among sub grantees; and updates on the proposed eight month program extension. Also, the forum was used to refresh sub grantees' understanding on some areas including SIMS and donor indicators, specifically FN_ASSESS, OVC_ACC and Gender Norms.

Sub awards

Despite the scale up interventions and increased targets, the program will not engage new sub grantees. Next quarter, the two performing sub grantees will extend to the new areas. WAMATA Dar will scale up to Temeke and the new wards in Ilala and Kinondoni while Faraja in Morogoro expands to new wards in Morogoro municipal council.

This quarter, the program continued to work closely with its CSOs partners in building their capacity to serve OVC. A total of TZS 449,306,200 was disbursed to all 7 Sub grantees out of which TZS 358,549,760 was used for implementation of activities during the quarter.

Visits from the Donor

USAID Team Visit to Zanzibar

A team of three USAID staff headed by Pamoja Tuwalee Agreement Officer Representative (AOR) visited the program Unguja, site from 5th through 9th October 2015. The team had an opportunity to learn from our unique SILC model in Zanzibar; and review sub grantee filing system as a key component of OVC case management. The sub grantee visited was ZAMWASO.

While there, the team spent time to re-orient regional and sub grantee staff on new PEPFAR strategic direction and OVC case management; reviewed ZAMWASO documentation and filing system; and met with some beneficiaries.

With regard to PEPFAR strategic direction, the team insisted that the focus should be the epidemic control and the program should contribute to the focus. Further, the team emphasized collaboration with other players to ensure beneficiaries access HIV related services adequately. During meeting with beneficiaries who were caretakers supported with start-up kits and SILC group representatives, the team was informed on the successes the beneficiaries have attained through the support from the program. The USAID team insisted on the good use of the resources and the support to their MVC while also making sure they utilize available health facilities to know their HIV status and subsequently take the appropriate steps including enrolment to CTC for the positive ones. The team reviewed ZAMWASO filing system and insisted on case management and the need to observe confidentiality of beneficiaries' information. Also, they paid a courtesy call to the Director of Social Welfare and various issues were discussed including improved collaboration and networking. The DSW commended the collaboration from Pamoja Tuwalee program and called upon more involvement in various program activities to enhance sustainability.

USAID team members during discussion with MVC caretakers

During the visit, the program had already transitioned some MVC in Unguja based on household vulnerability assessment conducted earlier during the year. When ZAMWASO shared their experience on this with USAID team, the latter was very much impressed so they invited the former to Pamoja Tuwalee partners' meeting at the Mission on 21st October, 2015 to share the process as a best practice and to also learn on bi-directional best practice that was to be presented by Pamoja Tuwalee program/WEI partner CSO from Arusha.

Specific key recommendations from the team after discussions with program and sub grantee staff, and beneficiaries were:

◊ Retrain volunteers to include HIV services in their package to OVC and orient them on skills of identifying and managing HIV+OVC, adolescents and caretakers
◊ Ensure functional bi-directional referrals and linkages with health facilities and proper documentation of the same
◊ Enhance integration of HIV/AIDS into SILC groups and other community platforms
◊ Ensure proper filing as it is a key component in case management.
◊ Integrate SIMS into supportive supervision checklist as SIMS is a critical tool that needs to be taken very seriously
◊ Ensure continuous documentation of success stories
◊ Find a way to motivate volunteers dealing with HIV+ OVC

US Senate Staff Visit

On October 14, 2015, the program was honoured by the visit from US Senate staff, accompanied by 2 USAID Tanzania staff. They visited a program site in Morogoro municipal council. During the visit, he met with the program management and Faraja Trust Fund (the implementing partner) staff; SILC group; and children club representatives in Mafiga ward.

The SILC group presented on what they do and support provided by the group to OVC in Mafiga ward. They also gave testimonies on how SILC has contributed to their economic improvement and subsequently enabled them to meet the basic needs of their children; and knowledge on HIV/AIDS and other health related issues. On the other hand, children club representatives talked about what they are taught in the clubs; and how they have used the skills acquired from the clubs to improve their lives and social interaction with other children peers, teachers, parents and other community members; they also shared their dreams and plans for the future. They cited how HIV/AIDS education has made them understand that interacting with HIV+ colleagues such as playing together will not infect them; also that they have learnt that they should not stigmatize HIV+ colleagues or family members.

Generally, the visit went very well and the visitor appreciated as:

- SILC members were active and able to explain what they do to improve their income through savings and loans. The members demonstrated how being in the group has benefited them in other social matters including: education on health, supporting members during family shock such as sickness, death etc.
- SILC members demonstrated their ability to support OVC through their OVC fund. They expressed their determination to ensure all OVC caretakers in their ward are motivated to become SILC members so that they can support their children including those who are HIV+.
- In spite of good work done through SILC, members explained that they have limited entrepreneurship skills, and asked to be supported with the same. This has been addressed by the program as reported under activity 2.2.

OBJECTIVE 1

Increase the capacity of communities and local governments to meet the needs of OVC and their households in an innovative, efficient and sustainable manner by enhancing their competencies to provide support and by improving communication, coordination and collaboration across sectors

To ensure quality and sustainable care, protection and support to OVC, Pamoja Tuwalee Program/FHI 360 has been strengthening the capacity of LGAs, and other community structures including local implementing partners, MVCCs, community volunteers, and MVC caretakers. At the national level, the program has actively participated in the development and review of relevant policies and guidelines aimed at improved OVC wellbeing. Also, the program shares best practices and provides monthly updates on implementation.

In response to the recent requirement to scale up within PEPFAR priority regions, this reporting period the program focused on identification of OVC and activities aimed at reaching increased number of OVC, adolescents and their caretakers with HIV services.

Also, efforts continued on advocacy for increased participation and support of public private partners and other community providers in care, protection and support to MVC.

Strengthening LGAs to implement the NCPA II

Over the past years, the program has been strengthening the capacity of relevant LGA staff such as Social welfare officers, Nutrition officers and Community development officers. This has been done through formal trainings and involving them on: joint supportive supervision; training of community volunteers and MVCC members; MVC Identification and Nutrition Assessment Counselling and Support (NACS) exercises, among others. To enhance their coordination capacity, District Implementing Partners Group (DIPG) forum was established in 15 districts and 2 in Unguja and Pemba. These are aimed at promoting effective referrals and linkages among district MVC stakeholders. In FY 2016, these have been broadened to include HIV (specifically Care & Treatment) as the program strives to increase the number of MCV and adolescents accessing HIV services. The program has also been strengthening the capacity of LGAs in budget allocation through active participation in planning and budgeting sessions where we advocate for the same. During this quarter the following activities were accomplished.

1.1.1. Provide TA to LGAs during their annual planning and budgeting process and advocate for increased MVC support

Throughout the implementation, program staff have been participating in LGAs pre-planning, planning and budgeting meetings with the aim of advocating for allocation of more financial resources on care, support and protection of MVC as per the NCPA II. In this FY 2016, the program will continue to follow up on the commitments made by councils in their MTEF plans and urge that budget allocated for MVC be utilized accordingly. Per previous years, DSWOs will be encouraged to continue to advocate at the district level to

ensure the needs of MVC that have been transitioned and or expect to be transitioned are met, specifically in the 21 sustained districts.

1.1.2. Facilitate smooth transitioning of all MVC in the sustained districts to LGAs and other community structures by September 2016

In FY 2015, the program conducted assessment to determine the level of vulnerability for each MVC household in the sustained districts. The results of the assessment indicated that, about 9% (10, 566) meet graduation criteria, 54% (63,393) meet transition criteria and 37% (43,436) meet the criteria for continued support. Subsequently, a total of 12,706 MVC and their households were transitioned to SILC groups, MVCCs and LGAs in Morogoro region and Zanzibar (Unguja and Pemba); while 2,106 MVC were graduated.

Although the process of transitioning MVC and caretakers commenced last quarter, during this reporting period no transition was done. This is because of the third round proposed program extension that allows for provision of services for a bit longer with specific targets for each district including the sustained ones. Based on that, this quarter the program continued with provision of services in the sustained districts. The plan is to transition 70,889 MVC and their households in the third and fourth quarters of this FY 2016.

1.1.3. Provide TA to District Social Welfare Officers to implement MVC care and support

During this quarter, involvement of DSWOs in various program activities continued as one way of building their capacities and cementing ownership of program interventions. The main two activities that they were involved in were joint supportive supervision and MVC identification exercise as elaborated in the latter part of this report.

1.1.4. Strengthen supportive supervision

Supportive supervision is a key approach used by the program to build the capacities of LGAs, CSOs, Community volunteers, MVCCs and SILC groups. It is used as a vehicle for mentoring and coaching at the same time monitoring program implementation. In this quarter, both routine and joint supportive supervision were conducted by the sub grantee staff. OVC focal persons visited MVCCs, SILC groups, local leaders, MVC households, children clubs and CTCs/health facilities and major activities accomplished were:

- Collection and review of volunteer reports from volunteers; updating volunteers on intensifying efforts on identification of new HIV+ MVC and supporting them and their households with HIV services, including ART adherence.
- Sensitization to SILC members to increase membership of PLHIV in their groups, increase contribution to OVC funds.
- In Morogoro, visit to 16 CTCs to introduce the new focus of the program and seek collaboration between CTC and community volunteers so as to reinforce linkages and networking for improved services to HIV+ MVC and adolescents.

***Joint supportive supervision with District Social Welfare Officers*:** Joint supportive supervision was done in 15 districts namely Mkuranga, Rufiji, Kisarawe, Kibaha TC, Kibaha DC, Chakechake, Micheweni, Mkoani, Wete, Kaskazini A, Kaskazini B, Magharibi, Mjini, Kusini and Kati. During the exercise, among district personnel who joined sub grantee staff included DSWOs, DCDOs and District Beekeeping Officer, DACC and District HBC coordinator. In the remaining districts, the joint supportive supervision was not conducted as DSWO were occupied with other council priorities. In their respective districts, the teams visited MVCCs, SILC groups, MVC households, older MVC, and community volunteers. During the visit it was noted that: SILC Groups are been used to provide HIV education such as importance of caretakers to know their HIV status through accessing HTC and adherence counseling for HIV+ caretakers; following Ward Development Committee (WDC) meetings conducted in 2015, some villages have incorporated MVC issues in their WDC meetings. Also, MVCCs with support from Ward Executive Officer (WEO) have started to implement their action plans developed during WDC meetings; and MVCCs managed to link 195 MVC and their caretakers to TASAF III program for education, food and Economic strengthening support.

The supportive supervision teams discussed their observations with the respective beneficiaries and sub grantee staff and action points agreed on. Some of the key ones are tabled below.

Table 2: Summary of supportive supervision observations and recommendations

Observation	***Action point/Recommendation***
Some project beneficiaries are reluctant to go for HIV counselling and testing as they are afraid of community stigmatization	Community volunteers were urged to educate community members on the importance of knowing their sero-status, so that they get proper treatment and support. Volunteers were also urged to intensify advocacy to community members on ant-stigma to those living with HIV
Insufficient number of MVC caregivers joining SILC groups	CRPs and MVCC members should sensitize as many parents and caregivers to join SILC groups
Lack of official registration for the established SILC groups	Collaborative efforts should be made by sub grantee staff and DSWOs to make sure the groups are registered. DCDO at the ward level should visit all SILC groups in the ward and review their constitutions before submit to district office for registration (for all the groups which are ready and qualify registration).
Many of the caretakers engaged in gardening but lack technical skills and support from extension workers	Focal persons encourage and support caretakers to meet extension workers for support
Some MVC households were not enrolled for TASAF111 support as local leaders claimed they are ineligible	Focal persons and DSWO will advocate for enrolment of MVC households in TASAF 111 support

1.1.Facilitate OVC identification in the scale up saturation and aggressive districts

In this FY, the program plans to increase its targets from 12,738 to 166,832 in Dar es Salaam; and 2,870 to 15,080 in Morogoro Municipal council. In Magharibi and Mjini districts in Unguja, there will be no new MVC identification as the current reach is above the district annual target of 920. To contribute to PEPFAR 3.0 and 90-90-90 HIV global initiative in controlling HIV pandemic, the program will use different approaches in identifying OVC ranging from national MVC identification to identification through NACS as described below. All the identified MVC will be registered in respective street/wards.

1.2.1. Identify OVC in the scale up districts in Dar es Salaam and Morogoro Urban district through the national identification process and Strengthen MVCCs to Lead Community Support for MVC

MVC Identification

During this reporting period, Pamoja Tuwalee / FHI 360 conducted MVC identification exercise from 2nd to 21st December 2015. The exercise involved three districts of Ilala, Kinondoni and Morogoro municipal council covering a total of 35 wards per below details:

Table 3: Coverage of MVC Identification Exercise

Region	District	Ward
Dar es Salaam	Ilala	Kimanga, Kisukuru, Segerea, Bonyokwa, Kipawa, Kivule, Kiwalani, Tabata, Liwiti,Mchikichini, Pugu, Pugu Station and Majohe
	Kinondoni	Kimara, Saranga, Kwembe, Mbezi, Wazo, Goba, Hananasif, Magomeni, Kigogo, Makulumla, Sinza and Kijitonyama,
Morogoro	Morogoro MC	Chamwino, Kiwanja cha ndege, Kichangani, Mwembesongo, Uwanja wa Taifa, Mbuyuni, Mafisa, Kihonda, Mazimbu and Sultani Area

The MVC identification exercise involved consultation meetings with key Social Welfare personnel who shared the experience they have in the community and advised on wards to be covered. At the LGA level, District Social Welfare Officers were used as TOT to train ward facilitators. The latter in turn conducted the exercise at community level. The ward facilitators included Mtaa Executive Officers and Extension Officers operating in the respective mitaas.

To ensure quality, the actual exercise was preceded by training of facilitators both at the district and ward levels. At the community / mtaa level, a meeting was convened for local government leaders including i.e. Mtaa/Village Chairperson, Mtaa Executive Officer and four members to inform them about the MVC

Identification, making sure that they understand the purpose of the exercise but also to get their buy-in and support. The community was not left aside, through public meetings, MVC were pointed out, MVCC members selected and funds to support MVC contributed. This was done to ensure that the community owns the process from the very beginning, for subsequent commitment to support MVC in their localities. Through the process, it was learnt that; if involved from the beginning local leaders as well as community members are very

committed and supportive especially when the activity is of benefit to their respective communities.

One of community meetings during MVC Identification

Despite the achievements of the exercise, some challenges were encountered including:

- Time constraint: the exercise is very involving especially the transect walk where the houses are far apart or when the house has more than seven family members.
- Poor cooperation from some households - some were not ready to expose their vulnerability status
- Some household heads were not seen as they went out to look for their daily bread, hence missing some information.

Through the exercise more than 80,000 MVC and their households were identified within the 35 wards.

Formation and strengthening MVCCs to lead community support for MVC

As part of MVC identification exercise, about 200 MVCCs were formed, based on the requirement of the National Costed Plan of Action (2013-2017) for MVC which states that MVCC be established in every mtaa/street/village to spearhead and coordinate MVC services within their localities. The new MVCCs were trained on their roles and responsibilities in OVC support. Thereafter, they participated in the identification of MVC within their localities (mitaas) and subsequently compiled MVC registers for the same. These committees will continue to spearhead and coordinate MVC support in their areas per the national guidelines. To ensure quality, the DSWOs and sub grantee staff will continue to follow-up and mentor the committees through supportive supervision. The new MVCCs contributed a total of TZS 5,632,100 (USD 2681) as community funds to support MVC.

After processing the data for the whole MVC identification exercise in quarter two, a more detailed report with conclusive data will be shared.

Identify HIV+ OVC through health facilities and HBC

In Kilosa and Mvomero supervision with DACC and District HBC Coordinator visited 17 CTCs to meet with In-charge to discuss working modalities between HACOCA and CTC especially on the issue of effective bi-directional linkages for quality and comprehensive services to HIV+ MVC and adolescents. As a way forward, it was agreed that, HACOCA should present all the names to CTCs to verify if those names are real and those MVC are registered in the CTC database.

Identify OVC who are HIV+ through NACS exercise

While conducting Nutrition Assessment Counselling and Support (NACS) to MVC and their caretakers, community volunteers have been mentored and coached to provide referral to HTC to those MVC that found with acute malnutrition. In this reporting period, 366 (184 male and 182 female) including those with acute/severe malnutrition and were referred to health facilities for further support including HIV testing.

1.2.4. Implement OVC and their households case management

During OVC identification process, the program takes records of each individual child and their households. Through community volunteers, the child and the family are assessed and care plan developed in collaboration with the latter. Thereafter, relevant services are provided based on the needs identified by the assessment. The service provision is through direct support and referrals/linkages to other relevant service providers, mainly health facilities.

Since the identification process was done during the last two weeks of December 2015, next quarter, the program will ensure that history and other relevant data for each of the newly identified children/households is properly filed and stored. Also, the community volunteers will: ***provide services and/or referrals and advocacy*** **-** will link the family to age-appropriate services and support as outlined in the volunteers' job aid; ***document the progress*** **-** will continue to document in the family file any interventions done with the family; and ***make follow-up visits*** **-** will conduct regular household visits to assess how the situation is changing or improving.

Case management will continue until the family graduates from project support or be transitioned in case the program phases out before the family graduates.

1.3. Develop and implement capacity-building plans for existing MVCCs

By the end of FY 2015, a total of 627 MVCCs with more than 6,000 members had been formed and the program in collaboration with social welfare officers had been trained them on their roles and responsibilities; resource mobilization; child protection; and up-dating of MVC master register per the national guideline. This was done through formal training and mentoring during supportive supervision.

This quarter, immediately after they were formed, the new 200 MVCCs were trained for two days and two days practical by participating in MVC households' needs assessment. At the same time, the existing 627 MVCCs continued to be capacity build by sub grantee staff and DSWOs through supportive supervision.

The outcomes of the training/capacity building are increasingly been realized as the committees demonstrate increased participation and contribution to OVC support per 1.3.2 below.

1.3.1. Advocate for membership of community volunteers in MVCC

Program continued to encourage community volunteers to be part of MVCCs as volunteers having undergone different trainings use their expertise to facilitate linkages among stakeholders; inform MVCC plan and implementation; and share program activities and reports. During this reporting period community volunteers who are members in the MVCCs continued to be 98% as last quarter.

1.3.2. Support LGAs to develop Village/Shehia-Level funds to support OVC

As one of the strategies to ensure sustainable MVC support, MVCCs as the goal owner of MVC support at community level have been trained among other things, resource mobilization. This has realized positive outcomes whereby a total of 428 OVC funds have been established through which in FY 2015 alone TZS 148,592,800 (US$ 70,758) was collected from communities coupled with non-financial contributions. To date, the funds has supported MVC with various basic needs, especially education and food. In this reporting period, a total of 324 (149 male and 175 female) MVC received support worth TZS 3,065,500 (US$ 1,451) through MVCC OVC funds.

1.3.3. Support savings, income-generation and food security activities among MVCCs

Addressing economic needs of MVCCs puts them in a better position to support MVC. For example, they cannot contribute towards OVC fund if they do not have income nor can they assist individual MVC who now and then call upon them in their homes. It is in this context that the program encourages MVCC members to join SILC groups for accessing soft loans for IGA activities. Community volunteers sensitize MVCC members during meetings and through home visits for those who are also caretakers. There is slow increase of MVCC members in SILC group as during this quarter only 9 members joined SILC. Focal persons and volunteers will continue to sensitize MVCC members to join SILC groups and/or other s savings and credit schemes in their localities.

1.4 Strengthening Local CSO Partners to Support MVC services

Following five year capacity building which included trainings, coaching and mentoring, the program identified four well performing CSOs. These are WAMATA Dar es Salaam, Faraja Trust Fund, HACOCA and WAMATA Pemba. Last quarter, two of these (i.e. WAMATA Dar es Salaam and Faraja Trust Fund) underwent USAID Pamoja Tuwalee CSO Capacity Assessment conducted by Deloitte BOCAR project. During this quarter, the two CSOs attended the Human Centered Design Think and Innovation Training. The training aimed at enabling CSOs to find solutions to problems and increase the impact of their work. It also served as a platform for giving feedback and certificates for the capacity assessment of the previous quarter.

The certificates were handed over by the USAID Mission Community-Based Services Team Lead on the last day of the workshop. Also, three Pamoja Tuwalee Implementing Partners (FHI360, WEI, and Africare) witnessed the certificates handover event. Meanwhile, the program continued to support CSOs to implement their respective plans developed through the organizational capacity assessment exercise.

1.5 Facilitate Meaningful Participation of the Business Community in MVC Support

Mobilization of resources from different stakeholders for OVC support is very essential as no single entity or sector can meet the needs of increasing number of OVC. Hence, from the very start, the program has been advocating for increased resources to support MVC from LGAs, MVCCs, Public Private Partners and other community members. As a result, private companies and individuals have continued to contribute either in cash or in kind to ensure MVC needs are met in their respective areas.

Establish and support Public Private Partnership that benefit MVC and their households

After realizing that the multinational and national entities are already experiencing donation fatigue while some are already committed under their corporate social responsibility, the target has been small and medium entities, both public and private as well as small sole proprietors.

Advocacy to private sector to contribute towards OVC support is an on-going activity in program implementation. This is much emphasized at the community level, where small amounts have been continuously realized from individuals and small business people. During this quarter efforts continued to mobilize support from PPP and a total TZS 97,785,000 was contributed by SILC groups, MVCCs, COMPASSION, TASAF III, FBOs and individual community members among others. The contribution was used to support 7,073 (3,389 male and 3,684 female) MVC with food, school materials, school fees, school uniforms, birth certificates, CHF, water guard and casual clothes. TASAF III covered 87% of the total contributions. The amount contributed is 36% lower compared to TZS152,105,700 reported last quarter. According to TASAF coordinator the decrease was due to delayed funding but those vulnerable households who missed will receive their cash soon after arrival of funds.

Table 4: Summary of PPP Support to MVC – Oct to Dec 2015

Region	Support Equivalent in ZS	Male	Female	Total
Pwani	63,676,800	2627	2834	5461
Morogoro	9,134,600	274	306	580
Dar es Salaam	24,349,600	459	520	979
Zanzibar	624,000	29	24	53
Total	***97,785,000***	***3389***	***3684***	***7073***

Source: Quarterly Report October to December 2015

The program will continue advocating for increased resources to support MVC especially those who are HIV + and the ones at risk of HIV infection.

1.6 Improve Coordination among and across sectors and zones

Effective coordination is very important in ensuring comprehensive care and support for MVC and avoid duplication of resources among implementing partners (IPs). Over the past years the program has been strived to improve coordination at National and District levels through facilitating the DIPG meetings and participating in different meeting organized by LGAs which aimed at improving coordination and collaboration among IPs. Below are activities accomplished during this quarter.

1.6.1 Mapping Government and donor activities in program coverage areas

In this quarter, efforts were made to bring together the community and social service providers and CTC and other health facility service provides to ensure increased access to HIV services to both OVC and their caretakers through bi- directional referrals and linkages among the social and health facility service providers. Next quarter follow ups will be made and concrete plans firmed up.

1.6.2 Support coordination and networking through DIPGs at district/zonal level

The establishment of DIPGs at district level not only help to improve coordination among IPs but also contribute in strengthening collaboration and networking which contribute to enhanced care and support to OVC. During the reporting period the DIPGs meetings were conducted in 14 districts in the mainland as well as in Unguja and Pemba and the following were the issues and deliberations from the discussions.

Table 5: Summary of DIPG Meeting Deliberations

ISSUE	DELIBERATION
In Kisarawe and Mkuranga Child Protection Teams (CPTs) lack collaboration from MVC caretakers when required to testify at the court when their children are raped. Many cases are closed due to lack of evidence, for example, in 2015, only 1 rape case ruling was made whereby, the perpetrator was sentenced to 30 years in jail while more than 10 rape cases were closed in Mkuranga because police lacked enough evidence to sue the perpetrators.	The program and other relevant stakeholders will intensify community sensitization on the importance of reporting GBV and VAC issues and the repercursion of not reporting to both the victims/survivors and the society at large.
In Bagamoyo DMO reported on the challenge to get children to be tested.	WAMATA to participate in the up-coming Home Based Counselling and Testing exercise (HBCT) per DMO's request. The HBCT will focus specifically on children. To get a large turn-out, community volunteers to raise awareness to the community members on the children HBCT.
In Morogoro MC, Morogoro DC and Kilombero some MVC stakeholders are not familiar with activities of other stakeholders in the same area.	DSWO for each district tasked to conduct mapping exercise and share the list of MVC stakeholders with DIPG members in the next DIPG meeting.

In Kibaha TC, TASAF coordinator reported having started to provide cash transfers to enrolled households and during this quarter more than TZS 57 Million was transferred to poor households.	The coordinator shared the list of beneficiaries who are enrolled in TASAF III program, through which other stakeholders can identify MVC households receiving cash transfers in order to ensure complementarity rather than duplication of efforts among stakeholders.
In Pemba: (a) GBV cases dominate but not much reported; (b) Extreme poverty within families facilitate child labour and (c) In-availability of birth certificate among the children - the institution responsible claims it is due to budget constraints.	(a) All participating entities left with implementation plan on promoting awareness to the communities on reporting GBV/VAC cases to the respective centres/authorities (b) Members agreed on promoting entrepreneurship skills and joining existing savings and credit schemes such as SILC for the households to improve their income source (c) The death and birth registrar promised that starting from 2016 the issue of birth certificates delays will be resolved
In Dar es Salaam social welfare officers reported on the challenge of inadequate manpower especially at ward level. This result in delay in service provision, as most issues are been attended at the district level.	The forum will continue to advocate to the relevant ministry to allocate adequate social welfare officers at the ward level.
In Unguja, after the transitioning and exit plan were shared, the takeover by other players including DSW	DSW promised to take over the roles while also increasing MVC budget. Also, DSW shared on MVC data base, shehia child protection teams trainings and development of Zanzibar MVC M&E plan.

Other deliberations were:

- Mapping should be done on service providers to facilitate referral and linkages among DIPG members
- Government representatives to make sure MVC needs are given priority in their MTEF
- Community awareness raising on MVC should be every one's responsibility in order to reduce GBV and VAC cases, DIPGs should come up with prevention measures.
- Members to be sharing their activities in order to avoid duplication of efforts but also to widen services provision through linkages, referrals and networking.

1.6.3 Conduct annual planning meeting with implementing partners and share experiences on best practices

The plan in FY 2016 is to hold informal meetings with sub grantees in their respective districts to discuss progress of implementation against the annual plans. However, during the reporting period the sub grantees had an opportunity to share and discuss lessons learnt and challenges encountered. This was during the annual planning and budgeting meeting held in December 2015 in Morogoro as reported under program management section of this report. In the subsequent periods, the informal meetings will be held per plan.

1.6.4 Coordination among implementing partners across zones through monthly implementing partners Group (IPG) meetings

The plan is to continue to actively participate in the monthly national IPG meeting; relevant stakeholders/donor meetings and other relevant forums/technical working groups such as Police Coordination

Working Group, Child Protection, TACAIDS Impact Mitigation Technical Working Group, Accelerating Children HIV/AIDS Treatment (ACT), TACAIDS Adolescents Task Force for Young People, as well as Monitoring and Evaluation technical working group. In this reporting period, we participated in the following.

Most Vulnerable Children Implementing Partners Group

The government coordinates a National forum that brings together all MVC Implementing Partners (IPG). The group meets on monthly basis for experience sharing as well as progress made by each partner. In this reporting period, the program continued to attend the monthly MVC IPG meetings and shared the monthly updates accordingly.

Meeting to finalize the Health Sector Operational Plan for GBV and VAC

The Ministry of Health and Social Welfare in collaboration with the University of California San Francisco, organized a workshop to write the final draft of the Health Sector GBV and VAC Operational Plan. The workshop was attended by 20 participants including government staff from MOHSW - the Reproductive and Child Health, Department of Social Welfare; Ministry of Constitution and Legal Affairs; the National Bureau of Statistics, University of Dar es Salaam; and from partners such as FHI360, MDH, Engender Health and TAYOA.

The meeting took place in Kibaha from 23rd to 28th November 2015. Partners were required to share their annual activities to be incorporated in the plan to avoid duplication of efforts and to ensure that all GBV and VAC interventions are in line with the national plan. The meeting was informed that partners whose activities will not appear in the plan will not be able to implement those activities especially those which require the involvement of the ministry.

USAID Partners Meeting

In October 2015, USAID invited its partners to provide updates and other information necessary for the implementation of their respective projects. During this meeting, partners had opportunity to discuss issues including how best partners could closely work with the government, how to integrate project and/ or government budgets to facilitate successful implementation of government and project priorities; and how to mobilize resources from the government for sustainability. Besides that, partners were given updates about changes in operations particularly the use of VAT. Partners were informed that they will have to procure items in full price and request for reimbursement afterward after sending the VAT exemption form. This process would be supported by USAID after partner's request. Moreover, partners were informed of online directory and resources/ links that could assist research and getting of information e.g. www.hfrportal.ehealth.go.tz

DREAMS Partners & Evaluation Meeting

This meeting took place on 9th and 10th November, 2015 brought together all USAID partners expected to implement DREAMS initiative. The meeting was an opportunity for partners to understand in-depth about the initiative; specific targets and regions to be reached; and other initiatives that could be integrated in the program i.e. HURU program. Also, USAID explained expected interventions i.e. provision of school subsidies, GBV prevention, parenting skills, HIV prevention education and menstrual hygiene through HURU program.

DREAMS Communications Strategy Workshop

This second DREAMS workshop was conducted on 23rd and 24th November 2015 for USAID partners implementing DREAMS initiative. The workshop was geared to: understand existing materials with partners and gaps; key themes that partners have to communicate to their target; identify DREAMS target audience, communication channels and tools to reach them; and propose messages for each targeted audience. The meeting was participatory and involved research findings as a starting point to identify themes for the communication. After identification of target audiences, the partners developed proposed themes for DREAMS.

OBJECTIVE 2

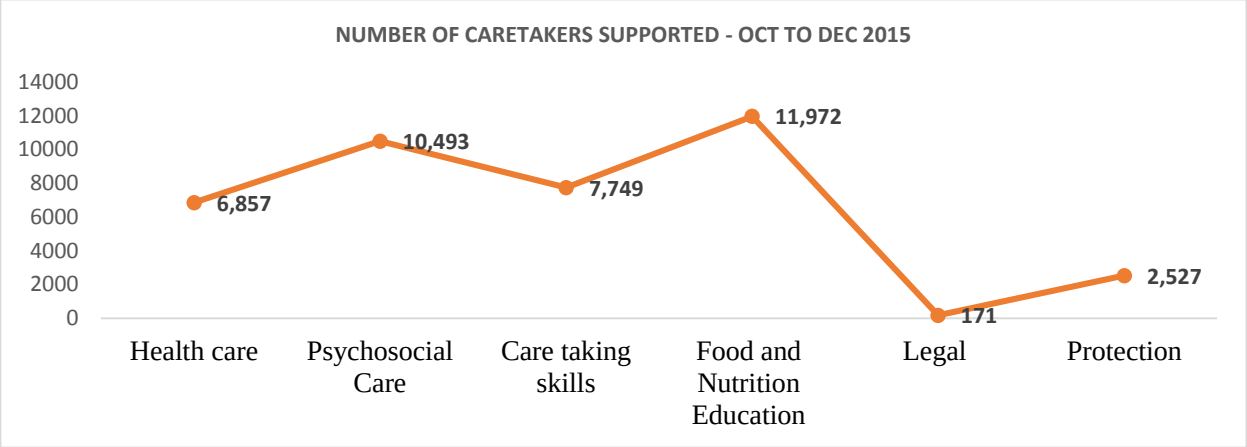
Increase the capacity of households to protect, care and meet the basic needs of OVC in a sustained way by improving their caretaking, livelihood and health-seeking skills

While most MVC caretakers are willing to take the responsibility of caring for MVC, they face the challenge of inadequate necessary skills and low income. Based on that the program supports these caretakers with training on different aspects aimed at improving and providing sustainable care, support and protection to their children. In the past five years of program implementation, about 35,736 caretakers have been trained on parenting skills, PSS, food and nutrition, economic strengthening and child protection among others.

The training of caretakers is mostly done by community volunteers through home visits. The latter are normally trained with necessary skills and in turn impart the same to caretakers. During this reporting period efforts continued in building the capacity of volunteers and caretakers on different areas per below details.

2.1 Provide training for household caretakers in caretaking skills, PSS and reducing stigma/discrimination

During this reporting period, volunteers continued to educate caregivers on ensuring the wellbeing of their children by meeting their needs like school requirements, psychosocial support and provision of healthier foods and others. A total of 39,769 caretakers were equipped with different skills including: healthcare, PSS, nutrition education, MVC caretaking skills, legal and child protection as reflected on the figure below. The total reach is equivalent to 55% of 72,264 annual target, and 134% of 22,782 reported last quarter. The sharp rise is due to the fact that almost the whole of last quarter political campaign was the main activity in communities, hence oftentimes caretakers were not found at home.



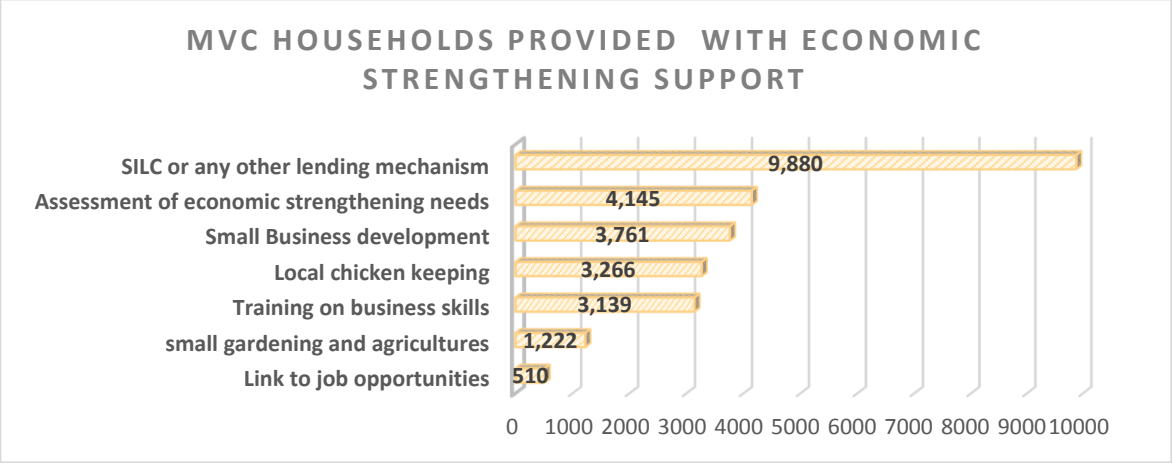
Source program quarterly report Oct - Dec 2015

Following MVC identification carried out towards the end of this quarter, a total number of 1,013 new volunteers were selected by community members and the respective local leaders. Next quarter, these will be trained on OVC caretaking skills with emphasise on providing HIV related services and referrals to MVC adolescents and their households. After the training, through home visits among other roles the volunteers will train caretakers of the newly identified MVC within the scale up wards.

2.2 Provide training and other support to increase savings and improve livelihood for MVC households

Economically weak households including those caring for the MVC lack access to affordable means of income. Low income affects household's capacity to protect and meet the basic necessities of children who are under their care including: proper nutrition, shelter, access to education, and health care resulting into vulnerability. In recognition of that, the program provides a range of training focused on increasing the income of MVC households. These trainings equip caretakers with skills such as: developing business ideas, diversifying their economic activities and establishing and managing small businesses. In establishing small businesses, caregivers are sensitized on the importance of and encouraged to join SILC groups. The latter provides opportunity to save, take loan and engage in income generating activity for increased income and subsequently improved wellbeing of children and other family members.

During this reporting period, volunteers reached caretakers with economic strengthening support which included SILC, link to job opportunities, small scale gardening and agriculture, local chicken keeping, training on business skills, small business development and assessment of economic strengthening needs as indicated in the figure below.

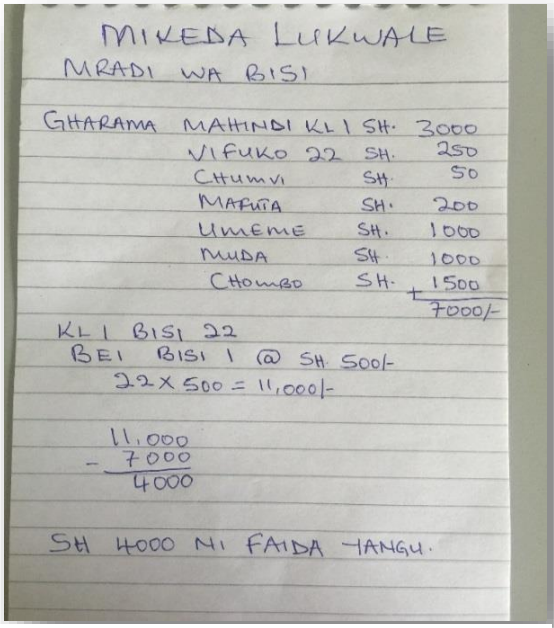


Source: quarterly report October - December 2015

During the quarter, the cumulative savings through SILC initiative increased by 28% to TZS 2,449,953,751 (US$1,166,644) from TZS 1,921,247,721 reported last quarter. Also, cumulative OVC fund grew to TZS 161,209,360 (US$ 76,766) equivalent to 20% when compared to last quarter amount of TZS 134,278,040. This is attributable to the 62 new SILC groups formed and continued efforts in sensitizing and encouraging caretakers, MVCC members, older OVC and community members to form/join SILC groups. The annual plan is to form new 382 SILC groups. Although 62 is just 16% of the annual target, a larger number is expected in quarter two and three after training of new community volunteers and CRPs within the scale up wards and district. The SILC group meetings were also used as a platform for HIV messaging, training caretakers on child protection, HIV education and nutritional education. Realized results from SILC include increasing number of caretakers who have been gradually able to support their children with basic needs such as education and enhanced household food security after they established IGAs through SILC and increased their incomes.

Facilitator clarifying a point during training

A three day training on entrepreneurship was conducted to 27 caretakers (male 4, female 23) of Nguvukazi SILC group in Morogoro Municipal council. The topics covered included developing a business idea, innovations in business, record keeping, calculating profit and loss, qualities of an entrepreneur and market assessment. At the end of the training, participants were able to develop simple business ideas showing how they will apply the acquired knowledge.



Business idea developed by one of the training participants

Table 6: Summary of composition and financial status of SILC groups – Dec 2015

Region	Number of Groups	Sex			Member category					Total Savings	Contribution for OVC fund
		Male	Female	Total	MVC	MVC HH	MVCC	Volunteer	Other Community		
Morogoro	262	1,422	5,161	6,583	14	1,068	220	265	5,052	1,191,614,613	59,777,860
Dar es Salaam	166	535	3,902	4,437	32	1,001	181	169	3,054	582,282,830	50,807,170
Zanzibar	84	467	1,908	2,375	10	519	74	63	1,709	311,936,128	16,075,500

Pwani	221	1,350	3,967	5,317	316	2,241	320	165	2,260	364,120,180	34,548,830
Total	**733**	**3,774**	**14,938**	**18,712**	**372**	**4,829**	**795**	**662**	**12,075**	**2,449,953,751**	**161,209,360**

Source: Regional quarterly report October –December 2015

2.2.1 Training on entrepreneurship skills and SILC initiative to community resource persons and DSWOs

Community Resource Persons (CRPs) are selected community members trained by the program on establishment and managing of Savings and Internal Lending Communities (SILC) groups. To date 508 CRPs have been trained and in turn have facilitated formation and management of 733 SILC groups as reported above. In order to ensure that the trained CRPs provide HIV+ education through SILC groups, the program provides on job training on HIV basic skills. During this quarter, CRPs were trained on nutrition for HIV+ and on the importance of preparing balanced diet using locally available food. This was done during their monthly meetings.

2.2.2 Introduce micro-franchise model for youth business development

In FY 2015 the program postponed the initiation of a micro-franchise business model following the general election and other conflicting priority. Discussions are underway with the franchisors to ensure that the initial preparation are in place while the continued to mentor and coach the identified adolescent.

2.2.3: Regular CRPs meetings

The program supports monthly CRP meetings as one way of continuous mentoring and coaching them in establishment and management of SILC groups. The meetings are used as a platform for learning and experience sharing. During this reporting quarter, the monthly meetings were utilized to refresh CRPs understanding on and re-emphasize the following;

- Encourage SILC group members to continue using the MVC fund to support MVC.
- Continue to sensitize and educate SILC group members on the importance of knowing and disclosing their HIV status and that of their children.
- Continue to collaborate and link caretakers with other stakeholders who provide livelihood support and in particular TASAF III.
- Provision of nutrition education and counselling to caretakers especially those who care for HIV+ MVC on the importance of preparing balanced diet using locally available food.

2.2.4 Conduct market linkage

Among other things caretakers are supported to access market for their products and produce. For MVC households markets are where, as producers, they buy their inputs and sell their products and produce; and where, as consumers, they spend their income from the sale of crops or from their economic activities, to buy food requirements and other consumption goods. The program links caretakers with traders and encourage

them to use local market information systems. During this quarter, community volunteers continued to support caregivers to explore potential markets within their localities.

2.2.5 Training on entrepreneurship skills and provision of start-up kits to MVC caretakers

Ensuring that caretakers are economically empowered and meet the basics of their children is one of the program goals. In attaining this, the program offers a range of trainings on entrepreneurship skills and support older OVC and caretakers with start-up kits for economic activities. During this reporting period increased incomes continued to be recorded among caretakers and older OVC following start-up kits provided in previous years. Older MVC who were supported are now able to earn income and support their families. Volunteer continued to encourage HIV+ MVC caretakers learn new skills regarding business and link them for job opportunities.

Older MVC learning how to sew

2.3. Support training and linkages to improve MVC household food security and nutrition

Low income remains one of the major causes of food insecurity which coupled with hunger remain persistent among poor communities including MVC households. In addressing this, the program provides nutritional education and encourage caretakers to prepare nutritional food for their children using locally available foods. In this reporting period 11,972 caretakers were reached, this equals 11% of 108,396 annual target. The reach is expected to increase during the year after training of 1,013 new volunteers planned for next quarter. These will reach OVC and caretakers with nutrition education and counselling. Meanwhile, community volunteers continue to provide various trainings such as small farming and agriculture as a means of increasing food security among MVC households.

2.3.1 Training on households' nutritional assessment, counselling and promotion of households food security

Scaling up Nutrition Assessment Counselling and Support (NACS) is one of the program strategies to provide nutrition support to MVC households. At the end of FY 2015, more than 800 volunteers had been trained on NACS. During this quarter additional 245 community volunteers were trained on NACS to reach more MVC with special consideration to those who are HIV+. The training aimed at, equipping volunteers with knowledge and skills on assessing nutritional status and provision of support to MVC identified with nutrition problems through nutrition counselling, and referrals to health facility for severe malnutrition cases. Key topics covered during the training were: meaning of malnutrition; causes effects and how to prevent it; and meaning of food. Community volunteers continue to provide nutrition counselling to the caretakers for malnourished MVC and monitor the progress. Additionally both the earlier and the newly trained volunteers conducted nutritional assessment to 32,665 (15,884 male and 16,781 female) MVC using Mid Upper Arm Circumference (MUAC) tapes. The assessment results were: 97% (31,543) of assessed MVC were in good health; 3% (1,045) were slightly malnourished whereas only 0.3% (82) were severely malnourished. About 366 MVC were referred to health facilities for therapeutic food, counselling and clinical management. Last quarter, 24,154 MVC were assessed - the 35% increase in number assessed and 94% on those referred is a result of increasing number of community volunteers rained on NACS.

Participants during practical session

Table 7: Results of MVC Nutritional Status Assessment – Oct to Dec 2015

Regions	Total assessed		(Green) Good health		(Yellow) Slight malnutrition		(Red) Severe malnutrition		Referred	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Morogoro	3398	3451	3024	3082	345	335	33	30	101	98
Zanzibar	1144	1041	1128	1028	14	12	2	1	2	1

Dar es Salaam	4643	4852	4635	4844	8	8	3	2	11	10
Pwani	6699	7437	6526	7276	169	154	5	6	70	73
Total	**15,884**	**16,781**	**15,313**	**16,225**	**536**	**509**	**43**	**39**	**184**	**182**

Source quarterly report October - December 2015

2.4 Support training on social, legal rights and establishment of community protection structures

In addressing child protection, the program in collaboration with the relevant government ministry departments and district councils has established and trained District Child Protection Teams (DCPT); and One Stop Centre (OSC) for GBV and VAC; and facilitated protection of Children Living and Working in the Street (CLWS). In this reporting quarter, the program continued to support DCPTs and OSC members and staff respectively. In areas like Mkuranga and Kisarawe it worked closely with the DCPTs to address challenges facing child protection efforts.

2.4.1 Facilitate utilization of Child helpline.

Pamoja Tuwalee has continuously raised awareness amongst communities on the existence of toll free Child helpline and how they can utilize it to report abuse cases. This 116 telephone line has enabled victims and survivors of GBV and VAC to be linked to social, legal and clinical services, through the department of social welfare, police, hospitals, MVCCs, DCPTs, and CSOs. In this reporting period, sensitization of community members on use of the helpline continued.

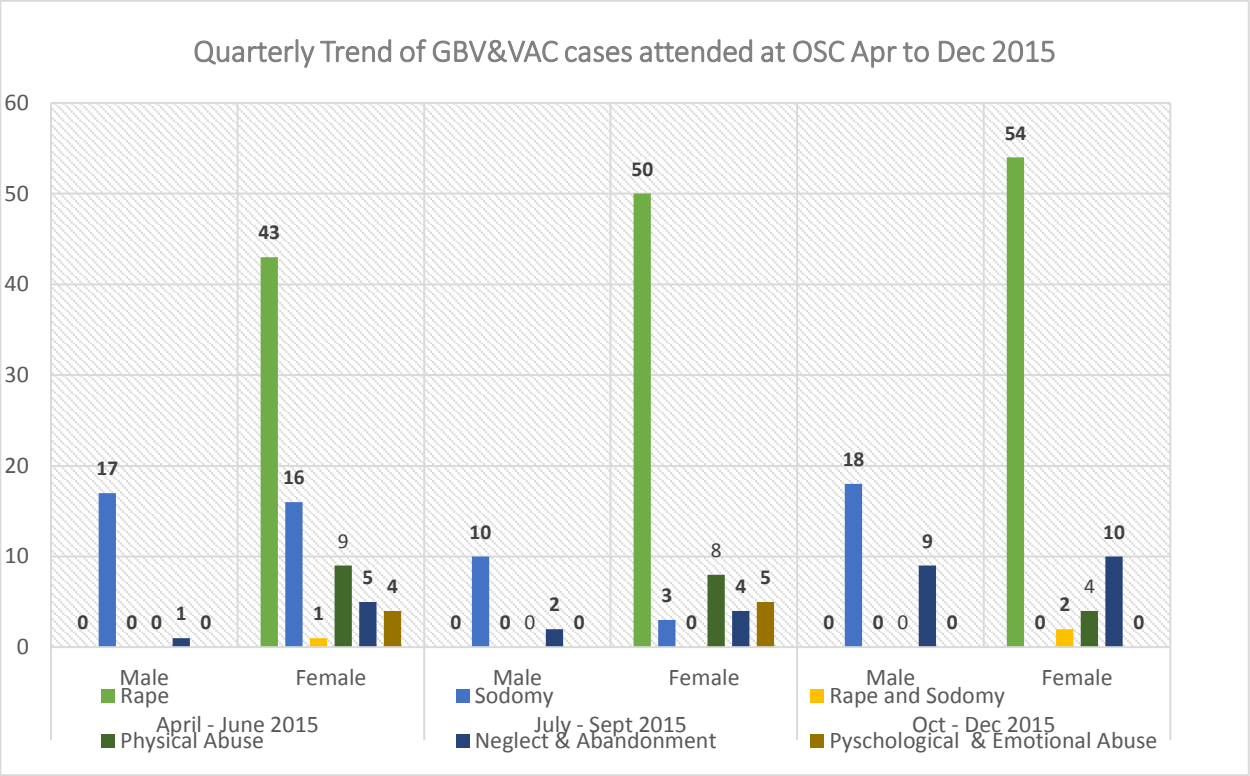
2.4.2 Strengthening GBV and VAC service provision at OSC

GBV and VAC are both a violation of human rights and form of discrimination. It has adverse effects and terrible consequences for its victims including loss of life, physical injuries and disability, chronic ill health, sexual and reproductive disorders as well as psychological and negative behavioral outcomes. The consequences on individual victims have wider social and economic implications on society as a whole hence its prioritization and integration into multi-sectoral programs is vital.

Pamoja Tuwalee program has put in place mechanism to ensure GBV and VAC survivors receive integrated and comprehensive services, through formation of child protection teams in Ilala and Kinondoni, MVCCs and establishment of OSC where GBV and VAC survivors receive timely, quality and free of charge services. Clients are referred to the center for services by CPTs, MVCCs, community volunteers and from police gender and children desks among others.

During this quarter the OSC services reached 97 GBV and VAC clients, cases attended included 54 rape equal to 55%; 18 sodomy equal to 16%; 19 neglect equal to 19.6%; 4 physical abuse equal to 4.1%; and 2 sodomy cases equal to 2.06%. Rape cases have continued to be the leading type of abuse compared to others because

women face higher risks of abuse due to norms, culture and male domination. This quarter 72% of all clients served were female, 87% last quarter, April – June 81% while male served were 27%, 13% and 19% respectively as depicted in the chart below. To date 832 cases have been attended at the OSC.



2.4.2.1. Contribute to the Ilala Municipality and national efforts in fighting GBV and VAC

In December 2015, Police Gender and Children Desk (PGCD) - Ilala Region in collaboration with other GBV and VAC key stakeholders organized 16 days of activism as part of local, national and international campaign to end miseries against women, children and other marginalized groups within the society. Pamoja Tuwalee program/FHI 360 as a key in the fight against GBV and VAC in Ilala municipality had planned to actively participate in the event. However, this was not done because unlike the initial plan, the event was conducted in a very subtle way and the PGCD did not convene further preparatory meetings after the initial two.

2.5 Facilitate access to community health insurance schemes for MVC households

Poverty limits the ability of MVC households to access health services. To address this the program promotes MVC households access to health care services through utilization of either TIKA (Tiba Kwa Kadi) or Community Health Funds (CHF) cards. During this reporting period in Mvomero district Upendo, Imani, Mwangaza and Tushikamane SILC groups supported 16 MVC (8 males and 8 females) with CHF cards amounting to TZS 160,000 (US$ 76). Additionally, MVCCs from Homboza and Manza village supported 10 MVC (5 males and 5 females) and 10 MVC (males 4 females 6) valued at TZS 100,000 (US$ 48) and TZS 120,000 (US$57) respectively with CHF cards.

In Kibaha district TASAF III 37 (18 males and 19 females) MVC households were supported with CHF cards worth TZS 814,000 (US$ 388). The CHF provided will help MVC caretakers and their MVC to easily access health services.

2.6 Link OVC caretakers to comprehensive health and psychosocial services along the continuum of care

The capacity of caretakers to care and protect their children depends largely on their psychological wellbeing. Caregivers are burdened with increased economic and child-care responsibilities and in some cases, may also be ill themselves. In addressing this, the program strives to build strong networks and referrals to ensure both MVC and their caretakers are receiving comprehensive services along continuum of care. This quarter, through linkages and home visits 17,350 caretakers were reached- 6857 with health services and 10,493 with PSS.

OBJECTIVE 3

Increase OVC household access to comprehensive, high-quality, age appropriate and gender-sensitive services by creating integrated community-level referral networks that strengthen the continuum of care

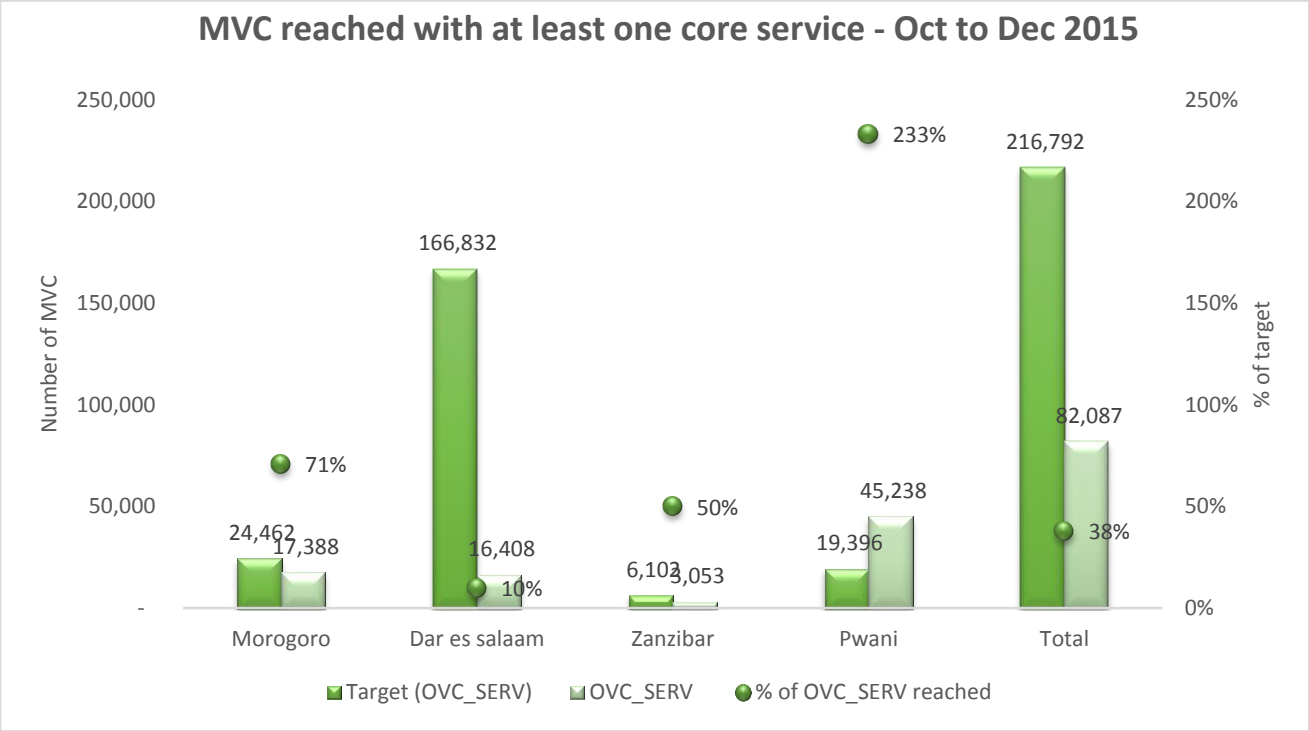
Children, like all human beings have needs, however, children have more needs than adults, and often adults must meet children needs because the child cannot do it him/herself. When parents, guardians or community members show concern and compassion in meeting children needs, they help them grow up into stable, caring, healthy and independent adults. Although the lists of children needs vary, the following five are basic: physical needs; a sense of safety and security; affection; self-esteem; and education. The program throughout its implementation has been responding to various MVC needs through direct services, linkages and referrals using community volunteers, MVCCs, LGAs, CPTs and IP staff. To pursue this the following activities have taken place during this quarter.

3.1 Continue to provide core, age-appropriate service package to OVC

Over the years, the program has been increasingly supporting more MVC with core services reaching a cumulative total of 143,724 MVC (70,492 and 73,232 female), and 95,061 MVC (45,226 male and 49,835 female) current in program to date.

Support efforts are focused on ensuring that in one quarter all MVC households are reached with at least one core service through program funds, community support, LGA support and referrals/linkages with other partners. Services provided include psychosocial support, health care, food and nutrition counselling, education, shelter, protection and HIV/AIDS related services.

During this reporting period, the program provided at least one core care service to a total of 82,087 (38,901 male and 43,186 female) MVC. This represents 38% of program annual target. Following identification of new MVC in the scale up districts, the program anticipates to reach more than 50% in the second quarter.



Source: Quarterly report July – September 2015

3.1.1 Provide support to HIV+ adolescents and those at high risk of HIV infection

The program has continued to prioritize support to HIV+ MVC, adolescent and caretakers and those at high risk of HIV infection to ensure that they receive education on HIV prevention, care, and support.

During this reporting period, through forums such as children clubs and SILC groups, efforts continued to promote HIV and AIDS education and refer beneficiaries for HTC, CTC and other social related services. Also, through volunteers home visits a total of 1,184 MVC, adolescents and caretakers were referred to health facilities and other stakeholders for health and HIV related services including HTC. The increase is a result of the training of youth volunteers and other program initiatives. Moreover, 4305 MVC and caretakers were supported to access HIV related services at health facilities and other institutions. The services were treatment for opportunistic infection, hygiene education.

3.1.2 Provide education support and vocational training

Education is a basic human right and a significant factor in the development of children, communities, and countries. Accessing education is important to all children, especially girls as it helps them break the intergenerational chains of poverty. Education is linked to all development goals, such as promoting gender empowerment - delay of marriage, reduction of gender based violence and violence against children, and

increase in self-confidence and decision-making power; improving child health and maternal health; reducing hunger; fighting the spread of HIV and diseases of poverty and stimulating economic growth. Through community engagement and involvement the program has witnessed an increase of community support and response to MVC educational needs.

During October to December 2015, through direct support, referral and linkages a total of 27,178 (13,431 male and 13,747 female) MVC were reached with education support including scholastic materials, school fees and other school contributions, equivalent to 33% of total OVC- SERV during this quarter - last quarter 29,363 MVC were supported. Also, communities continued to respond positively to sensitization on importance of education and the need for them to support the same. Below is the table with details on different community contributions to MVC education needs.

Table 8: Summary of MVC supported with education – Oct to Dec 2015

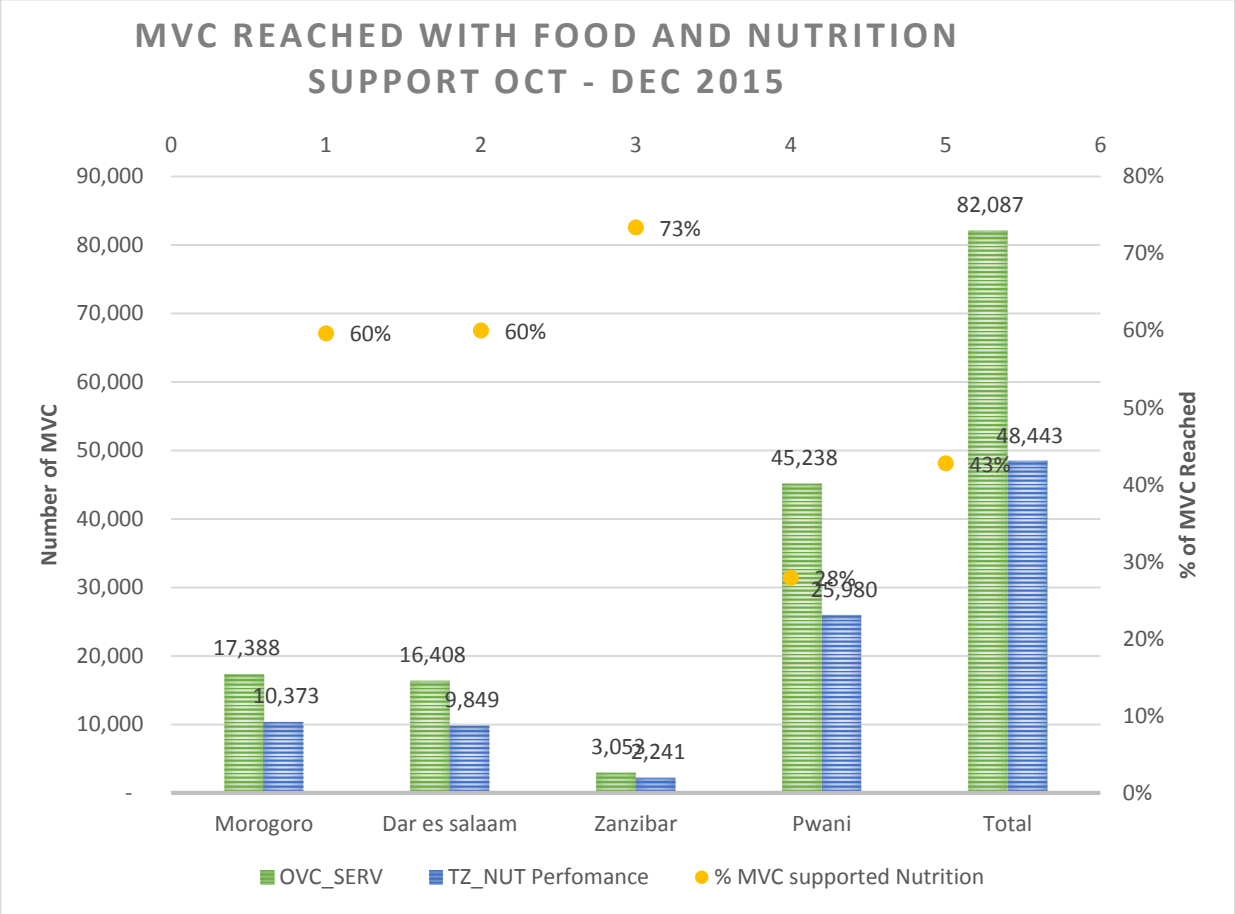
Region	***Source of support***	***Value of support in TZS***	***Male***	***Female***	***Total MVC supported***
Pwani	MVCCs, Good Samaritan and TASAF III	5,152,000	156	172	328
Zanzibar	SILC groups and TASAF III	337,00	19	19	38
Morogoro	SILC groups, TASAF III, CAMFED, and Community members	1,179,600	38	54	98
Total		**6,668,600**	**213**	**245**	**464**

3.1.3 Provide food and nutrition support

Taking balanced diet is vital for good health and wellbeing. Food provides our bodies with the energy, protein, essential fats, vitamins and minerals to live, grow and function properly.

To ensure MVC households have access to nutritious food and know how to prepare balanced meals, the program through trained community volunteers has been providing nutrition assessment, counselling and referrals to other stakeholders who provide food support or to health facilities for MVC who are found with acute or severe malnutrition.

During this quarter a total of 48,443 MVC (23,561 male and 24,882 female) were supported with nutritional services, including counselling, assessment and referrals. This represents 45% of the target of 108,396 for FY 2016 and 59% of OVC_SERV for this quarter (82,087). It is also the program's focus to ensure HIV+ MVC and their caretakers are given priority in accessing nutritional services. A total of 3,217 have been reached with nutrition assessment using MUAC tape equals to 16% of total FN_ASSES target for FY 2016.



Source: Quarterly Report October- December 2015

Also, communities, LGAs, MVCCs SILC groups, and other existing programs have been providing food support to MVC and their households as a result of program advocacy on increased MVC support. In.

3.1.4 Support Access to Primary Health Care

Provision of primary health care to MVC and their caretakers helps them to have access to different services such as health education, immunization, water treatment, HIV counselling, ART adherence counselling, sanitation and hygiene education and even medical services when one falls sick.

The program makes efforts to ensure that MVC and their households access HIV related services in complying with the PEPFAR 3 pivot 90 90 90 including MVC knowing their HIV status. Community volunteers promote HTC services to MVC, adolescents and caretakers whereby a total of 3,217 HIV+MVC were assessed using MUAC tape, they were educated on hygiene, living positively with HIV, and counselled on nutrition issues.

In Pwani region 1135 (591 male and 544 female) MVC were provided with WASH education. Also the program through linkage with HBC Life program 17 (14 male and 13 female) MVC were supported with water guards for water purification. In Kisarawe 138 MVC were referred for HTC and only 4 (1male and 3 female) MVC were found HIV+ while others have not yet disclosed their status. Additionally 3826 (1424

male and 2402 female) HIV+ MVC and caretakers were counselled on ART adherence. In Morogoro Nguvu Kazi SILC group supported 19 MVC (10 male, 9 female) with medication and CHF cards.

3.1.5. Contribute to DREAMS initiatives that aim to prevent HIV in adolescent girls and young women

The DREAM initiative aims at reducing HIV incidence among adolescent girls and younger women. Pamoja Tuwalee program/FHI 360 plans to undertake DREAMS intervention in FY 2016 targeting 1191 in school girls aged 10 to 14 years. As guided by the donor, DREAMS initiative will focus in six wards in Temeke district. Hence, no activities undertaken this quarter as scale up to Temeke will commence in quarter two.

3.1.6 Support shelter improvement

Most vulnerable children normally live with their families in communities. However, HIV and AIDS, migrant labour, parent illness and loss of parents has resulted in MVC being cared for by extended family.

The government encourages families to adopt or take OVCs into the family because upbringing in a family setting has been proved more effective than the institutional setting. Children are able to grow up in a family culture and a supportive environment. Adequate shelter and care is important to provide security and stability for all children and families. For children to feel and be safe, they need to know that where they live is protected from danger and therefore many caregivers experience extreme stress and need various types of community support in meeting this need.

In addressing the problem of poor shelter, community volunteers in collaboration with MVCCs and village leaders have been raising awareness to community members to rehabilitate or renovate poor MVC shelter by using their labour force and other locally available resources.

During this quarter, Pwani region supported a total of 81 MVC (39 male and 42 female). 1 female was supported with house renovation by Bagamoyo district council which costed TZS 1,500,000 (US$ 714) and other MVC were supported with casual clothes and shoes worth TZS 856,000 (US$ 407). Likewise, in Morogoro 170 MVC (73 male and 97 female) were provided with clothes, mattresses and shelter renovation amounting to TZS 560,000 (US$266).

3.1.7 Provide family based care/psychosocial support

Both MVC and caretakers have emotional and social needs which if not met will put them at higher risk of HIV infection, and for the ones already infected their needs are even more pronounced. The program empowers community volunteers to address these needs during home visits. During the reporting quarter, volunteers continued to be mentored and coached on how to provide psychosocial support to MVC at high risk of HIV infection, HIV + MVC, adolescents and caretakers. Out of 39,769 MVC caretakers served 10,493 (26%) were supported with PSS.

3.1.8 Child Protection

All children including Most Vulnerable have the right to protection. They have the right to survive, to be safe, to belong, to be heard, to receive adequate care and to grow up in a protective environment. Family is the first line of protection for children and parents or other caregivers are responsible for building a protective and loving home environment. Schools and communities are also responsible for building a safe and child-friendly

environment outside the child's home. Therefore in the family, school and community, children should be fully protected so they can survive, grow, learn and develop to their fullest potential.
Deliberate efforts have been made in ensuring that children are protected from all types of abuse and neglect. These include training of community volunteers, MVCCs and other service providers to understand the basics on preventing and responding to abuse cases; establishment of district child protection teams in Kinondoni and Ilala districts; and facilitation of the OSC for responding to abuse cases. In collaboration with local government and village authorities MVC have been receiving both direct support including awareness raising on child rights and responsibilities which are being taught during children club sessions and during home visits. Children are also referred to other service providers where deemed necessary for further support.

During this reporting quarter WAMATA Pemba reached 57 (25 male and 32 female) MVC caretakers with education on the importance of registering their new born babies so that they acquire birth certificates timely. Also, a total of 124 cases of abuse were reported: (97) at Amana OSC, 22 cases in Morogoro, 4 cases in Dar es Salaam and 1 case in Zanzibar.

3.2 Support District/Zonal IPG to expand and improve comprehensive referral networks that strengthen the continuum of care

The Program for the past years has been involved in improving coordination at districts level through facilitating the establishment and running of District Implementing Partners Group (DIPG) meetings and participating in different meetings organized by LGAs aimed at improving coordination and collaboration among implementing partners. The program has continued to utilize existing networks to complement services given to MVC and their households through referral system aiming at increasing care and support to OVC.

During this quarter, a total of 16 District/Zonal DIP conducted. They brought together 395 (182 male and 213 female) participants from council and other OVC and HIV Care & Treatment partners. Refer to 1.6.2 above for more details.

OBJECTIVE 4

Empower OVC, particularly females; contribute to their own wellbeing by improving their resilience as well as their livelihood and self-care skills

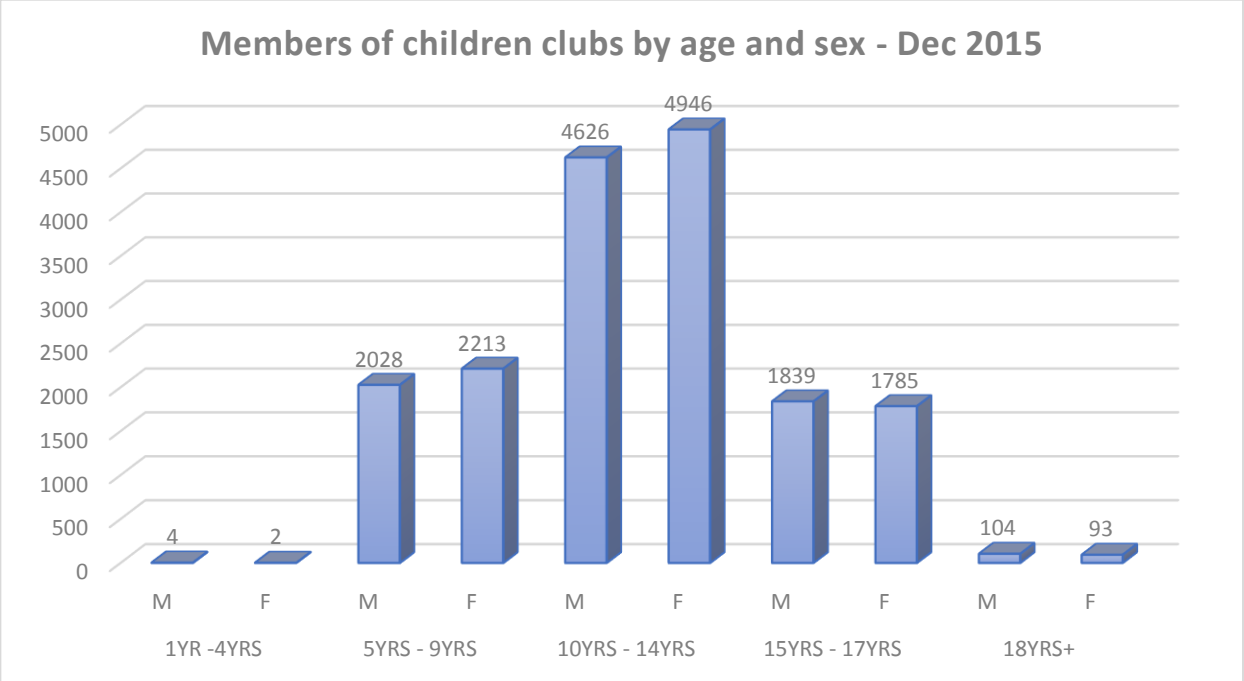
As in previous years, Pamoja Tuwalee program has ensured that MVC (including girls, disabled and HIV+ MVC) are closely monitored, supported and empowered to improve their resilience, self-esteem, knowledge and skills. The program has used community volunteers for knowledge and capacity building of the MVC and caretakers through education and mentoring through home visits, children club sessions, and school visits. While continuing to receive support from the program, MVC, caretakers and community have practically demonstrated that health and social care is their responsibility. Details of the activities for this quarter are provided below.

4.1. Establish and manage youth and children clubs

4.1.1 Children clubs

Children club is one of effective platforms to address children psychosocial needs and copying skills. The program has trained community volunteers as club attendants responsible for formation and management of the clubs. Using a guide developed by the program, the attendants provide children club members age and gender life skills, HIV and AIDS education, Sexual and Reproductive Health (SRH), with other recreational and sport events for socialization and attraction to children attending the clubs. The clubs have educated adolescents on basic rights, sexual and reproductive health, and HIV prevention using club training manuals supplemented with other educational materials such as SI MCHEZO magazines. Through clubs, participants are also informed about procedures to report cases of GBV and VAC when they occur and the importance of HIV testing.

In this quarter, the program undertook build capacity of club attendants to ensure that the established children clubs remain active even after donor funding particularly in sustained districts. Implementing partners focal persons visited the clubs, mentored and provided necessary support to club attendants. In Morogoro region 2 new children clubs were established (in Kilosa and Mvomero districts) with a total number of 58 participants (18 males and 40 females). This makes a cumulative total of 553 children clubs with 17,640 members (8,604 males and 9,036 females) members. The composition of children remains almost similar among boys and girls at 49% and 51%, respectively.



4.1.2 Establish post-test clubs

In FY 2016, the program plan to support and /or establish post-test clubs for youth and adolescents in the scale up districts. These clubs are expected to enrol HIV+ and some few non HIV+ members as a strategy to reduce stigma. These are planned for the next quarter.

4.2. Provide gender and age appropriate HIV and AIDS education

Throughout its implementation, the program has emphasized on provision of HIV and AIDS education that is age and gender appropriate. Caretakers through home visits and/ or community groups such as SILC have been receiving HIV and AIDS education and being sensitized on the importance of knowing their HIV status through HTC. Children and adolescents are reached through clubs and school visits wherein they receive health education with emphasis on HIV and AIDS prevention, access to HTC, SRH, disclosure, and adherence to ART.

During this reporting period, the program has prioritized its provision of HIV education to MVC, adolescents and caretakers who have already disclosed their HIV status. Out of 3,800 HIV+ clients enrolled, the program was able to reach 3,217 PLHIV with health education through volunteers. The program has promoted adherence to ART, educated on positive living with HIV; and equipped clients with economic strengthening skills to improve their economic status which in turn would allow them purchase nutritious food. Compared to the last quarter where the program reached only 67% of PLHIV, the program in this quarter, has provided its services to 85% of all PLHIV enrolled into the program. The reasons for this increase include the program shift to support more HIV+ clients and willingness of clients to disclose their HIV status to volunteers. Meanwhile, the remaining 15% of PLHIV was not reached because it was close to December vocational seasons and most PLHIV and/ or volunteers travelled away from their local areas for vocation.
Besides the above efforts, the program has reached all 82,087 MVC, adolescents and caretakers enrolled to the program with age and gender appropriate HIV health education (through clubs, SILC groups, school and/ or home visits) in all regions.

4.3 Provide support to MVC who are victims of Gender Based Violence and training to increase community capacity to assist GBV victims

Gender Based Violence (GBV) is a serious problem that limits the ability of men, women, and children to enjoy their basic human rights and fundamental freedom. Despite its prevalence in most countries, GBV is often not addressed. GBV is rooted in gender inequality and gender norms, often serving to reinforce gender inequality at different levels. Women's subordinate social, economic, and legal status often makes it difficult for them to get help once violence occurs.

The Tanzania government is against all forms of GBV and VAC in the country. This is because of its knowledge on negative consequences that GBV and VAC cause to victims and society in general. GBV and

VAC weakens the safety, dignity, overall health status, and human rights of individuals and the security of nations.

During this quarter, a total of 5,180 MVC (male 2,338 and 2,842 female) were reached with gender norm services. This equals to 14% of the annual target for FY 2016 and is expected to be more than 50% in the next quarter. Additionally, a total of 124 GBV and VAC cases were attended per details above.

4.4 Support access of birth registration for MVC

Every individual including a child has a right to identify. Thus, MVC as human beings have rights to have their birth certificates. Through implementing partners, the program identify MVC with no birth certificates and educate/sensitize caretakers, MVCCs and other community members on the need to facilitate children to access birth certificates.

In this reporting period, the program observed community response to support MVC in their respective areas whereby the MVCCs at Mloganzira in Kisarawe and Manza and Homboza supported 25 MVC to get their birth certificates worth TZS 320,000 (US$120).

4.5 Support MVC membership on MVCCs

Having children representation in MVCC is important to ensure that children concerns and needs are constantly known by MVCCs. Hence, the program has been advocating for MVC involvement and participation in MVCC by representation of two MVC (1 Male and 1 Female) in every MVCC. In this reporting period, it was ensure that all the newly formed MVCCs have children representation.

4.4 Provide MVC with disabilities with accurate information about their rights and HIV/AIDS

MVC and adolescents with disabilities remain at higher risk to HIV infection compared to non-disabled. With some not been able to self-help, they become highly vulnerable to physical and / or other forms of sexual violence and abuse. The program make efforts to reduce vulnerability and improve the wellbeing of MVC with disabilities through education to caretakers on the rights of disabled children; HIV and AIDS education (HIV prevention, HTC, Care and Treatment including available facility and non-facility services); SRH; and primary health care.

During this reporting period, a total 604 (316 males and 288 females) MVC and adolescents with disability were reached with information about their rights and HIV prevention. Moreover, MVC and adolescents with disability and the community were supported to:

- Participate in children clubs. This in turn facilitated reduction of stigma/self-stigma and improved social skills i.e. through social interaction with other children.
- Raise awareness to facilitate reduction of GBV and VAC to people with disabilities; and address the attitudinal barriers within the wider community

MONITORING AND EVALUATION

5.1. PMP Review

As a living document, Pamoja Tuwalee program /FHI 360 reviews its PMP on annual basis based on the necessary amendment in the program implementation. Last quarter, the PMP was reviewed to incorporate changes proposed under the six month extension. This quarter, further review was done to the PMP to following the proposed eight month extension to include some new indicators among others.

5.2 Support to sub grantees

The program continued to provide support to sub grantees, specifically on improved filing of case management; preparation of quality quarterly reports as well as monitoring the accomplishment of the planned activities as per set time frame. Also, sub grantee data was reviewed and feedbacks provided for improvement.

PRIORITY ACTIVITIES FOR NEXT QUARTER - JANUARY TO MARCH 2016

- Conduct OVC Caretaking Training to 1013 to community volunteers
- Process data collected on OVC Identification within the scale up districts
- Identification MVC in Temeke District
- Enrol OVC served by PASADA in Dar es Salaam region
- Introduce DREAMS intervention in Temeke

LIST OF APPENDIXES